

lassHealth Level I Preadmission Screening (PAS)

This form must be completed by the nursing facility for **all individuals** who, regardless of payment source, are admitted to a nursing facility. This form **must be kept permanently** in the resident's medical record. A licensed nurse or licensed social worker employed by the nursing facility must complete both sides of this form before the applicant's admission, as mandated by the federal Omnibus Budget Reconciliation Act (OBRA) of 1987.

	Nursing Facility Provider Information	Nursing Facility App	plicant Information
	Provider number	MassHealth ID or SSN	
	Name	Name	
	Address	Address	
	City, ZIP code	City, ZIP code	
	Telephone number	Date of birth	Gender F
e	ction 1: PAS for Mental Retardation or Deve	elopmental Disability	
	Does the nursing-facility applicant have a documented diagnost disability?	·	
	Has the nursing-facility applicant received services for mental individuals with mental retardation and/or developmental disa		
	Does the nursing-facility applicant exhibit any evidence that m disability?	•	-
	If you answered no to all questions in Section 1, skip Section 2 an	d proceed to Section 3.	
e	ction 2: Convalescent Care (following an acute	e inpatient hospital stay)	
	Is the nursing-facility applicant seeking admission for convalescen following an acute-inpatient-hospital stay?		The state of the s
e	ction 3: Level I Determination for Mental Re	etardation or Develop	mental Disability
	Check all that apply.		
	\square Level II PAS is not indicated because there is no diagnosis or $\mathfrak c$	evidence of mental retardation or	developmental disability.
	Level II PAS is not indicated because the applicant is seeking a exceed 30 days directly following an acute-inpatient-hospita		certified by a physician not to
	$\ \ \square$ Level II PAS is indicated and must be completed before $\ \ \square$	fore admission . Date of comple	etion:
	☐ Approved by DMR for nursing-facility admission. (The DMR a	pproval letter must be in the medi	cal record.)
	Date of nursing-facility admission:		
	Related diagnoses and comments:		
	Signature:RN, LPN, LS	W Date:	Time:
	(Circle one.) Note: You must notify DMR only when MR/DD is indicated.		
	Did you call and notify DMR on the day of admission?	yes (date)	no
	Did you fax this page within 48 hours to DMR?	yes (date)	no

PAS-1 (Rev. 12/06) Please complete other side. ►

lame of Applicant:		
tion 4: PAS for Menta	ıl Iliness	
		ment history of any of the following major mental
disorders? Check all that ap	Oly. Affective Disorders	
Psychoses Cabizanhrania		
☐ Schizophrenia☐ Paranoia	☐ Schizo-affective disorder☐ Bipolar disorder (formerly m	nanic depression)
Atypical psychosis		nan 10 years (date of diagnosis:
Severe Anxiety and Son	natoform Disorders (All must apply for Lev	vel II PAS referral.)
☐ Two years' duration with	documented symptoms in the last six montl	hs
☐ Inpatient psychiatric tre	•	
Psychoactive medication	n(s) administered for anxiety disorder (date o	t diagnosis:)
2. Has the nursing-facility appli	cant ever received any of the following treat	ments for unipolar depression?
		yes 🔲 r
		yes 🗆 r
c. Psychoactive medications)	yes □ ı
➤ 3. Does the nursing-facility app	licant exhibit any evidence of a major menta	l illness? yes □ r
If you answered no to all quest	ions in Section 4, skip Section 5 and proceed	to Section 6.
tion 5: Primary Diagr	noses/Conditions	
		nditions or meet any of the following descriptions?
=	ed as severe, debilitating, and bed-bound or b	•
☐ Alzheimer's disease or other	· dementia	☐ Severe brain injury
(requires supporting docum		☐ ES COPD with 24-hour oxygen
(requires supporting docum ☐ Comatose		☐ ES COPD with 24-hour oxygen☐ ES CHF with 24-hour oxygen
(requires supporting docum	entation) \square	☐ ES COPD with 24-hour oxygen☐ ES CHF with 24-hour oxygen☐ ES Amyotrophic lateral sclerosis (ALS)
(requires supporting docum ☐ Comatose ☐ Ventilator dependent	entation)	☐ ES COPD with 24-hour oxygen☐ ES CHF with 24-hour oxygen
(requires supporting docum ☐ Comatose ☐ Ventilator dependent ☐ Terminal illness with less that prognosis as certified by a p ☐ Unipolar depression, less that	entation) In six-month Shysician In 10 years' duration (date of diagnosis:	■ ES COPD with 24-hour oxygen ■ ES CHF with 24-hour oxygen ■ ES Amyotrophic lateral sclerosis (ALS) ■ ES Huntington's chorea ■ ES Parkinson's disease
 (requires supporting docum □ Comatose □ Ventilator dependent □ Terminal illness with less that prognosis as certified by a prognosis as certified	entation) Consist-month Consist-month Consistan Consist	■ ES COPD with 24-hour oxygen ■ ES CHF with 24-hour oxygen ■ ES Amyotrophic lateral sclerosis (ALS) ■ ES Huntington's chorea ■ ES Parkinson's disease
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